

**Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND
PROFESSIONAL REGISTRATION**

**Division 400—Life, Annuities and Health
Chapter 3—Medicare Supplement Insurance**

RECEIVED

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PROPOSED AMENDMENT

**SECRETARY OF STATE
ADMINISTRATIVE RULES**

20 CSR 400-3.650 Medicare Supplement Insurance Minimum Standards Act. The director is amending sections (1) - (3), (5) - (22), adding new sections (7), (9), (24) and (25), and amending Appendix C.

AMENDMENT PURPOSE: Section 1882 of the Social Security Act states that, if a state does not implement standards at least as restrictive as the NAIC Model, the state loses its authority to certify Medicare Supplement policies. The National Association of Insurance Commissioners (NAIC) modified the model Medicare Supplement Insurance Minimum Standards Act. This proposed amendment conforms to the NAIC Model and is necessary to maintain Missouri's authority to certify Medicare Supplement policies.

Purpose: This rule provides for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies, facilitates public understanding and comparison of such policies, eliminates provisions contained in the policies which may be misleading or confusing in connection with the purchase of the policies or with the settlement of claims and provides for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

(1) Applicability and Scope.

(A) Except as otherwise specifically provided in sections (5), [(10), (11), (14) and (21)] (5), (12), (13), (16), and (23), this rule shall apply to—

1. All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this rule; and
2. All certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this state.

(2) Definitions. For purposes of this rule—

(G) "Director" means the director of the Department of Insurance, Financial Institutions, and Professional Registration, of this state;

(H) "Employee welfare benefit plan" means a plan, fund or program of employee benefits, including, but not limited to those defined in 29 U.S.C. [s]Section 1002 (Employee Retirement Income Security Act);

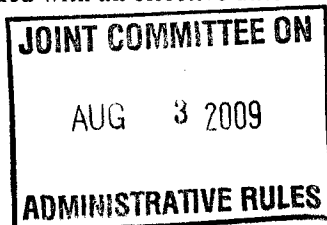
(M) "Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in section 1859 found in Title IV, Subtitle A, Chapter 1 of P.L. 105-33, and includes:

1. Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;
2. Medical savings account plans coupled with a contribution into a Medicare[-] Advantage medical savings account; and
3. Medicare Advantage private fee-for-service plans;

(P) "Pre-standardized Medicare supplement benefit plan," "Pre-Standardized benefit plan" or "Pre-Standardized Plan" means a group or individual policy of Medicare supplement insurance [plan] issued prior to July 30, 1992;

(R) ["Standardized Medicare Supplement Plan" means a Medicare supplement plan issued after July 30, 1992; and] "1990 Standardized Medicare supplement benefit plan," "1990 Standardized benefit plan" or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after July 30, 1992 and with an effective date for coverage prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

(S) "2010 Standardized Medicare supplement benefit plan," "2010 Standardized benefit plan" or "2010 plan" means a group or individual policy of Medicare supplement insurance issued with an effective date for coverage on or after June 1, 2010.



[(S)](T) "Secretary" means the Secretary of the United States Department of Health and Human Services.

(3) Policy Definitions and Terms. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms which conform to the requirements of this section.

(D) "Health care expenses" means, for purposes of section [(12)] (14), expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

(5) Minimum Benefit Standards for **Pre-Standardized Medicare Supplement Benefit Plan** Policies or Certificates Issued for Delivery Prior to July 30, 1992. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(B) Minimum Benefit Standards.

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period.

2. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount.

3. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days.

4. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days.

5. Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B.

6. Coverage for the coinsurance amount, **or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount**, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible.

7. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

(6) Benefit Standards for **1990 Standardized Medicare Supplement Benefit Plan** Policies or Certificates Issued for Delivery [or Delivered] on or After July 30, 1992 and with an Effective Date for Coverage Prior to June 1, 2010. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 30, 1992 and with an effective date for coverage prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(A) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible [amount and copayment percentage factors], **co-payment, or coinsurance amounts**. Premiums may be modified to correspond with such changes.

4. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

5. Each Medicare supplement policy shall be guaranteed renewable.

A. The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.

B. The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.

C. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph (6)(A)5.E., the issuer shall offer certificate holders an individual Medicare supplement policy which at the option of the certificate holder:

- (I) Provides for continuation of the benefits contained in the group policy; or
- (II) Provides for benefits that otherwise meet the requirements of this subsection.

D. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall—

- (I) Offer the certificate holder the conversion opportunity described in subparagraph (6)(A)5.C.; or
- (II) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

E. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

F. If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

7.

A. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period not to exceed twenty-four (24) months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

B. If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted effective as of the date of termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

C. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal rule) at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan (as defined in section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

D. Reinstitution of coverages as described in subparagraph (6)(A)7.B. and (6)(A)7.C.:

- (I) Shall not provide for any waiting period with respect to treatment of preexisting conditions;
- (II) Shall provide for resumption of coverage which is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and
- (III) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

8. If an issuer makes a written offer to the Medicare Supplement policyholders or certificate holders of one or more of its plans, to exchange during a specified period from his or her 1990 Standardized plan (as described in section (8) of this regulation) to a 2010 Standardized plan (as described in section (9) of this regulation), the offer and subsequent exchange shall comply with the following requirements:

A. An issuer need not provide justification to the director if the insured replaces a 1990 Standardized policy or certificate with an issue age rated 2010 Standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the director.

B. The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

C. An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six (6) months to any added benefits contained in the new 2010 Standardized policy or certificate not contained in the exchanged policy.

D. The new policy or certificate shall be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

(B) Standards for Basic (Core) Benefits Common to Benefit Plans A–J. Every issuer shall make available a policy or certificate including only the following basic “core” package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period.

2. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

3. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(C) Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans “B” through “J” only as provided by section (7) of this rule.

1. Medicare Part A Deductible. Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

2. Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

3. Medicare Part B Deductible. Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

4. Eighty Percent (80%) of the Medicare Part B Excess Charges. Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

5. One Hundred Percent (100%) of the Medicare Part B Excess Charges. Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

6. Basic Outpatient Prescription Drug Benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars (\$1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

7. Extended Outpatient Prescription Drug Benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible to a maximum of three thousand dollars (\$3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

8. Medically Necessary Emergency Care in a Foreign Country. Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

9. Preventive Medical Care Benefit. Coverage for the following preventive health services not covered by Medicare:

A. An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph B. and patient education to address preventive health care measures;

B. Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician;

C. *[Influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster as medically appropriate; and*

D.] Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars (\$120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

10. At-Home Recovery Benefit. Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

A. For purposes of this benefit, the following definitions shall apply:

(I) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;

(II) "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;

(III) "Home" shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence; and

(IV) "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four (24)-hour period of services provided by a care provider is one (1) visit.

B. Coverage Requirements and Limitations.

(I) At-home recovery services provided must be primarily services which assist in activities of daily living.

(II) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(III) Coverage is limited to—

(a) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare [-] approved home health care visits under a Medicare[-] approved home care plan of treatment;

(b) The actual charges for each visit up to a maximum reimbursement of forty dollars (\$40) per visit;

(c) One thousand six hundred dollars (\$1,600) per calendar year;

(d) Seven (7) visits in any one (1) week;

(e) Care furnished on a visiting basis in the insured's home;

(f) Services provided by a care provider as defined in this section;

(g) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(h) At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight (8) weeks after the service date of the last Medicare-approved home health care visit.

C. Coverage is excluded for—

(I) Home care visits paid for by Medicare or other government programs; and

(II) Care provided by family members, unpaid volunteers or providers who are not care providers.

[11. New or Innovative Benefits. An issuer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.]

(7) Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date of Coverage on or After June 1, 2010.

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage prior to June 1, 2010 remain subject to the requirements of section (6) of this regulation.

(A) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

4. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

5. Each Medicare supplement policy shall be guaranteed renewable.

A. The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.

B. The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.

C. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph (7)(A)5.E of this regulation, the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder):

(I) Provides for continuation of the benefits contained in the group policy; or

(II) Provides for benefits that otherwise meet the requirements of this section.

D. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall

(I) Offer the certificate holder the conversion opportunity described in Subparagraph (7)(A)5.C of this regulation; or

(II) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

E. If a group Medicare supplement policy is replaced by another group Medicare supplement policy

purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

7.

A. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

B. If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

C. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

D. Reinstitution of coverages as described in subparagraphs (7)(A)7.B. and (7)(A)7.C.:

- (I). Shall not provide for any waiting period with respect to treatment of preexisting conditions;
- (II). Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and
- (III). Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(B) Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M, and N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first (61st) day through the ninetieth (90th) day in any Medicare benefit period;

2. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

6. Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care

expenses.

(C) Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by section (9) of this regulation.

1. Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

2. Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period;

3. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first (21st) day through the one hundredth (100th) day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

4. Medicare Part B Deductible: Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

5. One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

6. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

[(7)](8) Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After July 30, 1992, and with an Effective Date for Coverage Prior to June 1, 2010.

(A) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in subsection[s] (6)(B) [and (6)(C)] of this rule.

(B) No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in paragraph (6)(C)11. and in section [(8)](10) of this rule.

(D) An issuer may use, in addition to the benefit plan designations required in subsection [(7)](8)(C), other designations to the extent permitted by law.

(G) New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

(9) Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or

Certificates with an Effective Date for Coverage on or After June 1, 2010.

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates with an effective date for coverage before June 1, 2010, remain subject to the requirements of section (6) of this regulation.

(A)

1. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in subsection (7)(B) of this regulation.

2. If an issuer makes available any of the additional benefits described in subsection (7)(C), or offers standardized benefit Plans K or L (as described in paragraphs (9)(E)8 and 9 of this regulation), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to the basic (core) benefits as described in paragraph (9)(A)1 above, a policy form or certificate form containing either standardized benefit Plan C (as described in paragraph (9)(E)3 of this regulation) or standardized benefit Plan F (as described in paragraph (9)(E)5 of this regulation).

(B) No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in subsection (9)(F) and in section (10) of this regulation.

(C) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this subsection and conform to the definitions in section (2) of this regulation. Each benefit shall be structured in accordance with the format provided in subsections (7)(B) and (7)(C) of this regulation; or, in the case of plans K or L, in paragraphs (9)(E)8 or 9 of this regulation and list the benefits in the order shown. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

(D) In addition to the benefit plan designations required in subsection (C) of this section, an issuer may use other designations to the extent permitted by law.

(E) Make-up of 2010 Standardized Benefit Plans:

1. Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in subsection (7)(B) of this regulation.

2. Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible as defined in paragraph (7)(C)1 of this regulation.

3. Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1, 3, 4, and 6 of this regulation, respectively.

4. Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit (as defined in subsection (7)(B) of this regulation), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1, 3, and 6 of this regulation, respectively.

5. Standardized Medicare supplement (regular) Plan F shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1, 2, 4, 5, and 6, respectively.

6. Standardized Medicare supplement Plan F With High Deductible shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in subparagraph (9)(E)6.B.

A. The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1, 3, 4, 5, and 6, of this regulation, respectively.

B. The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by regular Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be one thousand five hundred dollars (\$1,500) and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12)-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10).

7. Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare

Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1, 3, 5, and 6, respectively.

8. Standardized Medicare supplement Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

A. Part A Hospital Coinsurance sixty-first (61st) through ninetieth (90th) days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the sixty-first (61st) through the ninetieth (90th) day in any Medicare benefit period;

B. Part A Hospital Coinsurance, ninety-first (91st) through the one hundred fiftieth (150th) day: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

C. Part A Hospitalization After one hundred fifty (150) Days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

D. Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

E. Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the twenty-first (21st) day through the one hundredth (100th) day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

F. Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

G. Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

H. Part B Cost Sharing: Except for coverage provided in subparagraph (9)(E)8.I., coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

I. Part B Preventive Services: Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

J. Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars (\$4,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the U.S. Department of Health and Human Services.

9. Standardized Medicare supplement Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

A. The benefits described in subparagraphs (9)(E)8.A, B, C and I;

B. The benefit described in subparagraphs (9)(E)8.D, E, F, G, and H, but substituting seventy-five percent (75%) for fifty percent (50%); and

C. The benefit described in subparagraph (9)(E)8.J, but substituting two thousand dollars (\$2000) for four thousand dollars (\$4,000).

10. Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)2, 3 and 6 of this regulation, respectively.

11. Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1, 3 and 6, of this regulation, respectively, with copayments in the following amounts:

A. The lesser of twenty dollars (\$20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and

B. The lesser of fifty dollars (\$50) or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(F) New or Innovative Benefits: An issuer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

[(8)](10) Medicare Select Policies and Certificates. (A) (1) This section shall apply to Medicare Select policies and certificates, as defined in this section.

[(A)] (2) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

[(9)](11) Open Enrollment.

(A) [No]An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6)-month period beginning with the first day of the first month in which the applicant is both sixty-five (65) years of age or older and is enrolled for benefits under Medicare Part B.

1. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

(C)

1. If an applicant qualifies under either subsection ([9]11)(A) or (B), submits an application during the applicable time period referenced in those subsections, and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

2. If the applicant qualifies under either subsection ([9]11)(A) or (B), submits an application during the applicable time period referenced in those subsections, and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this subsection.

(E) No issuer required by subsection (B) of this section to issue policies or certificates of Medicare supplement insurance shall discriminate as to rates, between the rates charged to persons enrolled under subsection (B) of this section and the average rates charged for participation in that policy form number or certificate form number by persons enrolled in Medicare Part B by reason of age, or discriminate between persons entitled to enroll in the policy form number or certificate form number under subsection (B) of this section and other enrollees in the policy form number or certificate form number in other terms or conditions of the plan, policy form number, or certificate form number.

1. An issuer must demonstrate compliance with this section for each plan, type, and form level permitted under subsection ([13]15)(D) by either—

A. Charging a premium rate for disabled persons that does not exceed the lowest available aged premium rate for that plan, type, and form level; or

B. Charging a premium rate for disabled persons that does not exceed the “weighted average aged premium rate” for that plan, type, and form level, and providing, at the time of each rate filing, its calculation of the “weighted average aged premium rate” for each plan, type, and form level.

2. The “weighted average aged premium rate” is determined by—

A. First multiplying the premium rate (calculated prior to modal, area, and other factors) for each age band, age sixty-five (65) and over, by the number of Missouri insureds in-force in that age band to arrive at the total Missouri premium for each age band age sixty-five (65) and over; and

B. Then calculating the sum of the Missouri premium for all age bands age sixty-five (65) and over to arrive at the total Missouri premium for all age bands age sixty-five (65) and over; and

C. Then calculating the sum of the Missouri insureds in-force for all age bands age sixty-five (65) and over to arrive at the total number of Missouri insureds in-force for all age bands age sixty-five (65) and over; and

D. Then dividing the total Missouri premium for all age bands age sixty-five (65) and over by the total number of Missouri insureds in-force for all age bands, age sixty-five (65) and over to determine the weighted average aged premium rate.

3. Modal, area, and other factors may be added to the disabled premium.

(L) Except as provided in subsection (C) of this section and section ([21]23), subsections (A) and (B) of this section shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

[(10)](12) Guaranteed Issue for Eligible Persons.

(B) Eligible Persons. An eligible person is an individual described in any of the following paragraphs:

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual, **or the individual leaves the plan;**

2. The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is sixty-five (65) years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual’s enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

A. The *[organization’s or plan’s]* **certification of the organization or plan** has been terminated *[or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides];*

B. **The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;**

C. The individual is no longer eligible to elect the plan because of a change in the individual’s place of residence or *[because the plan is terminated for all individuals within a residence area or because of another]* **other** change in circumstances specified by the secretary, but not including termination of the individual’s enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), **or the plan is terminated for all individuals within a residence area;**

[C.] **D. The individual demonstrates, in accordance with guidelines established by the secretary, that—**

(I) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(II) The organization, insurance producer, or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

[D] E. The individual meets such other exceptional conditions as the secretary may provide;

3.

A. The individual is enrolled with—

(I) An eligible organization under a contract under section 1876 of the **Social Security Act** (Medicare risk or cost);

(II) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(III) An organization under an agreement under section 1833(a)(1)(A) of the **Social Security Act** (health care prepayment plan); or

(IV) An organization under a Medicare Select Policy; and

B. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph [(10)](12)(B)2.;

4. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because—

A.

(I) Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or

(II) Of other involuntary termination of coverage or enrollment under the policy;

B. The issuer of the policy substantially violated a material provision of the policy; or

C. The issuer, insurance producer, or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

5.

A. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under section 1876 (Medicare *[risk or]* cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, *[an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan),]* or a Medicare Select policy; and

B. The subsequent enrollment under subparagraph [(10)](12)(B)5.A. is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or

6. The individual, upon first becoming eligible for benefits under Part A of Medicare at age sixty-five (65), enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment; *[and]*

7. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in paragraph (E)4. of this section; and

8. Any individual who terminates Medicare supplement coverage within thirty (30) days of the annual policy anniversary.

(C) Guarantee Issue Time Periods.

1. In the case of an individual described in paragraph (B)1. of this section, the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

2. In the case of an individual described in paragraph (B)2., (B)3., (B)5. or (B)6. of this section whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage *[was]* is terminated;

3. In the case of an individual described in subparagraph (B)4.A. of this section, the guarantee issue period begins on the earlier of: (i) the date that individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage [was] is terminated;

4. In the case of an individual described in paragraph (B)2., subparagraph (B)4.B., (B)4.C., paragraph (B)5. or (B)6., of this section who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;

5. In the case of an individual described in paragraph (B)7. of this section, the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty (60)-day period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

6. In the case of an individual described in subsection (B) of this section but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment or the effective date of the loss of coverage under the group health plan and ends on the date that is sixty-three (63) days after the effective date.

(D) Extended Medigap Access for Interrupted Trial Periods.

1. In the case of an individual described in paragraph (B)5. of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in subparagraph (B)5.A. of this section is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph [(10)](12)(B)[6]5.; and

2. In the case of an individual described in paragraph (B)6. of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in paragraph (B)6. of this section is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph [(10)](12)(B)6.; and

3. For purposes of paragraphs (B)5. and (B)6. of this section, no enrollment of an individual with an organization or provider described in subparagraph (B)5.A. of this section, or with a plan or in a program described in paragraph (B)6. of this section, may be deemed to be an initial enrollment under this paragraph after the two (2)-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

(E) Products to Which Eligible Persons Are Entitled. The Medicare supplement policy to which eligible persons are entitled under—

1. Paragraphs [(10)](12)(B)1., 2., 3. and 4. is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F (including F with a high deductible), K or L offered by any issuer;

2. A. Subject to subparagraph B., paragraph [(10)](12)(B)5. is the same Medicare supplement policy in which the individual was most recently enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph 1. of this subsection;

B. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this subparagraph is:

(I) The policy available from the same issuer but modified to remove the outpatient prescription drug coverage; or

(II) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer;

[2]3. Paragraph [(10)](12)(B)6. shall include any Medicare supplement policy offered by any issuer;

[3]4. Paragraph [(10)](12)(B)7. is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage; and

[4]5. Paragraph [(10)](B)8. shall include any Medicare supplement policy offered by any issuer but only a policy of the same plan as the coverage in which the individual was most recently enrolled.](12)(B)8 shall include any Medicare supplement policy offered by any issuer, but only a policy of the same plan as the coverage in which the individual was most recently enrolled, if available, or, if not so available due to changes in the Medicare

supplement plan designs, a policy with a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L.

[(11)]13) Standards for Claims Payment.

[(12)](14) Loss Ratio Standards and Refund or Credit of Premium.

(A) Loss Ratio Standards.

1.

A. A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form the higher of the originally filed anticipated loss ratio or—

(I) At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

(II) At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies.

B. *[The ratios specified in this subsection shall be c]* Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(I) Home office and overhead costs;

(II) Advertising costs;

(III) Commissions and other acquisition costs;

(IV) Taxes;

(V) Capital costs;

(VI) Administrative costs; and

(VII) Claims processing costs.

2. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards *[(future loss ratio)]*.

3. For purposes of applying paragraph (A)1. of this section and paragraph *[(D)]*C)3. of section *[(13)]*(15) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

4. For policies issued prior to July 30, 1992, expected claims in relation to premiums shall meet—

A. The originally filed anticipated loss ratio when combined with the actual experience since inception (the lifetime loss ratio);

B. The appropriate loss ratio requirement from parts (A)1.A.(I) and (II) of this section when combined with actual experience beginning with January 1, 2006 to date; and

C. The appropriate loss ratio requirement from parts (A)1.A.(I) and (II) of this section over the entire future period for which the rates are computed to provide coverage.

(C) Annual Filing of Premium Rates. An issuer of Medicare supplement policies and certificates issued before or after the effective date of April 3, 1993, in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

[1]. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the director, in accordance with the applicable filing procedures of this state—

1. A. Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing;

B. An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date; and

C. If an issuer fails to make premium adjustments acceptable to the director, the director may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.

2. Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

[(13)](15) Filing and Approval of Policies and Certificates and Premium Rates.

(E)

1. Except as provided in subparagraph 1.A. of this subsection, an issuer shall continue to make available for purchase any policy form or certificate form issued after April 8, 1993, that has been approved by the director. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

A. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the director in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the director, the issuer shall no longer offer for sale the policy form or certificate form in this state.

B. An issuer that discontinues the availability of a policy form or certificate form pursuant to subparagraph 1.A. of this subsection shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.

2. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

3. *Effect of change in rating structure or methodology.*

A. *A change in the rating structure or methodology includes, but is not limited to:*

(I) A change between community rating, issue-age rating, and attained-age rating;

(II) A change in class structure (e.g., one class v. smoker/non-smoker class, unisex v. male/female classes);

and

(III) A change between rating for each age v. age-banded rates.

B.] A change in the rating structure or methodology shall be considered a discontinuance under paragraph 1. of this subsection unless the issuer complies with the following requirements:

[(I)]A. The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates; and

[(II)]B. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. Such actuarially equivalent policies or certificates shall be combined for filing purposes under paragraph (13)(H)1. The director may approve a change to the differential which is in the public interest.

[C. *Notwithstanding subparagraph B. of this paragraph, where an issuer changes a rating structure or methodology and rates calculated under the new methodology are not actuarially equivalent to the old rates, the change in rating structure or methodology will be considered a discontinuance under subparagraph (13)(E)1.A. The actuarial equivalency of rates must be determined by a comparison of weighted average premium rate under the old and the new methodology, except in the case of a change between attained-age and issue-age rating where the actuarial equivalency of the rates will be determined from a comparison of actuarial present value of lifetime premiums by age or age-band.]*

(F)

1. Except as provided in paragraph (F)2. of this section, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in section [(12)](14) of this rule.

2. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(G)

1. An issuer shall not present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after January 1, 2000, based upon attained-age rating as a structure or methodology. Notwithstanding, an issuer may continue in-force policies and certificates issued prior to January 1, 2000.

2. Where an issuer files for approval of a rate structure for policy forms or certificate forms which reflects a change in methodology from attained age to issue age, the issuer must demonstrate the actuarial equivalency of the rates proposed with the previously approved attained-age rates as required by paragraph [(13)](15)(E)3. If the policy forms or certificate forms were at any time approved by the director under an issue-age methodology, the issuer must use the most recently approved issue-age rate schedule as its proposed rate schedule for the policy forms or certificate forms and need make no further showing of actuarial equivalency under [(13)](15)(E)3.

(H) Filing requirements and procedures for change of Medicare supplement insurance premium rate and for annual filing of premium rates.

1. When an issuer files for approval of annual premium rates for a plan under subsection (12)(C) or a change of premium rates for a plan under subsection (13)(C), the following documentation must be provided to the director as part of the rate filing in addition to any other documentation required by law or regulation:

A. A completed Medicare Supplement Rate Filing Document (Missouri Form 375-0065, revised 10/98), which can be accessed at the department's website at www.insurance.mo.gov;

B. An actuarial memorandum supporting the rating schedule;

C. A report of durational experience (for standardized Medicare supplement plans only);

D. A projection correctly derived from reasonable assumptions;

E. A clear statement of all of the assumptions used to prepare the rate filing, including the source of trend;

F. All formulas used to prepare the projection except for formulas which can be ascertained from a cursory inspection of the projection itself; and

G. The issuer's current rate schedule and the proposed rate schedule for this state, including rates for disabled persons, if any, and all rating factors, including, but not limited to: area; smoker/non-smoker; standard/substandard.

2. The report of durational experience must contain for each calendar year of issue the following data by duration: incurred claims and earned premium; resultant loss ratio, and life -years. The durational split may be either by policy or certificate duration, calendar duration or calendar year of experience within each calendar year of issue.

3. The projection must—

A. State the incurred claims and earned premium, resultant loss ratio and corresponding life-years for each of the preceding calendar years beginning with the year in which the policy or certificate was first issued and must include the total for each category (incurred claims and earned premium, resultant loss ratio, and corresponding life-years) for all preceding calendar years;

B. State the projected incurred claims and projected earned premium, resultant loss ratios and corresponding life-years for at least each of the ten (10) calendar years subsequent to the rate filing and must include the total for each category (projected incurred claims and projected earned premium, resultant loss ratio, and corresponding life-years) for all projected calendar years;

C. Include a calculation of the sums of the combined total figures reported under subparagraph A. of this paragraph and those reported under subparagraph B. of this paragraph; and

D. Include, for pre-standardized Medicare supplement plans, the respective totals of the incurred claims and earned premium, resultant loss ratio, and corresponding life-years for the period beginning April 28, 1996, or alternatively, January 1, 1996, through the end of the projection period described in subparagraph B. of this paragraph.

4. Where assumptions include interest, the totals for incurred claims accumulated/discounted with interest, earned premium accumulated/discounted with interest, and the resultant loss ratio must also be shown in all parts of the projection described in paragraph (H)3. of this section.

5. Both the report of durational experience and the projection must report Missouri and national data with respect to incurred claims, earned premium, loss ratio, and life-years. The projection must also report this information both with and without the rate change requested.

6. The issuer must specify whether the figures reported as incurred claims were determined by adding claims paid to unpaid claims reserves or by the actual runoff of claims. The method of determining the incurred claims must be consistent throughout the filing and supporting documentation.

7. Changes in active life reserves or claims expenses may not be included in incurred claims in the rate filing or any supplemental documentation.

8. For purposes of this section, "incurred claims" means the dollar amount of incurred claims.

9. Earned premium reported in the rate filing or any supporting documentation must include modal loadings and policy fees. An adjustment for premium refunds, if any, must also be made to earned premium and the details of the adjustment must be provided to the director with the filing. Changes in active life reserves may not be included in earned premium.

10. Life-years reported in a rate filing or supplemental documentation must be calculated in the same manner as for refund calculations.

11. Rate filings for each plan, type, and form level permitted under subsection (13)(D) for standardized Medicare supplement plans marketed after June 30, 1998, must demonstrate compliance with the requirements of subsection (9)(E). The "weighted average aged premium," must be recalculated for each filing using current data, unless the issuer demonstrates compliance under subparagraph (9)(E)1.A. The figure used in the calculation for the total number of insureds in-force for all age bands, age sixty-five (65) and over, must be the same as the figure reported on Missouri Form 375-0065 for the "Number of Missouri Aged Insureds."

12. For standardized Medicare supplement plans, the Medicare Supplement Rate Filing Document, the report of durational experience, and the projection must be provided separately for each plan, type, and form level permitted under subsection (13)(D).

13. For pre-standardized Medicare supplement rate plans, the information contained in the Medicare Supplement Rate Filing Document and projection may be pooled within a type.

14. The rates, rating schedule and supporting documentation required to be filed under subsection (H) of this section as part of a rate filing and all supplementary documentation in connection with the rate filing must be accompanied by the certification of a qualified actuary that to the best of the actuary's knowledge and judgment, the following items are true with respect to the documentation submitted:

A. The assumptions present the actuary's best judgment as to the expected value for each assumption and are consistent with the issuer's business plan at the time of the filing;

B. The anticipated lifetime, future, and third-year loss ratios for the policy form or certificate form for which the rates are filed comply with the loss ratio requirements of subsection (12)(A) for policy forms or certificate forms of its type delivered or issued for delivery in this state;

C. With respect to rate filings concerning pre-standardized plans, the loss ratio for year 1996 (from April 28 or from January 1) through the end of the projection period complies with the loss ratio requirements of subsection (12)(A) for policies or certificates issued prior to July 30, 1992, and delivered or issued for delivery in this state;

D. Where the rate filing concerns a policy or certificate as to which rating methodologies have changed or are presented for approval based on a change in methodology, the percentage differential between the discontinued and subsequent (or new) rates has not changed;

E. All components of the filing, including rates, rating schedules, and supporting documentation, were prepared based on the current standards of practice promulgated by the Actuarial Standards Board;

F. The rate filing, including rates, rating schedule, and supporting documentation, is in compliance with the applicable laws and regulations of this state; and

G. The rates requested are reasonable in relationship to the benefits provided by the policy or certificate.

[(14)](16) Permitted Compensation Arrangements.

[(15)](17) Required Disclosure Provisions.

(B) Notice Requirements.

1. As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the director. The notice shall—

A. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

B. Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

2. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

3. The notices shall not contain or be accompanied by any solicitation.

(C) MMA Notice Requirements. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(D) Outline of Coverage Requirements for Medicare Supplement Policies.

1. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant.

2. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve (12)-point type, immediately above the company name:

“NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.”

3. The outline of coverage provided to applicants pursuant to this section consists of four (4) parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12)-point type. All plans [A–L] shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

4. The following items shall be included in the outline of coverage in the order prescribed below.

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale. (This sentence shall not appear after June 1, 2011.)

Basic Benefits:

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50

							75%		copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		50% Part A Deductible	75% Part A Deductible	50% Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$[4620]; paid at 100% after limit reached	Out-of-pocket limit \$[2310]; paid at 100% after limit reached	

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. [This paragraph shall not appear after June 1, 2011.]

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to subsection (9)(D) of this regulation.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the director.]

[PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

**** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.***

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* <i>Semiprivate room and board, general nursing and miscellaneous services and supplies</i> <i>First 60 days</i> <i>61st thru 90th day</i> <i>91st day and after:</i> <i>—While using 60 lifetime reserve days</i> <i>—Once lifetime reserve days are used:</i> <i>—Additional 365 days</i> <i>—Beyond the additional 365 days</i>	<i>All but \$[992]</i> <i>All but \$[248] a day</i> <i>All but \$[496] a day</i> <i>\$0</i> <i>\$0</i>	<i>\$0</i> <i>\$[248] a day</i> <i>\$[496] a day</i> <i>100% of Medicare eligible expenses</i> <i>\$0</i>	<i>\$[992](Part A deductible)</i> <i>\$0</i> <i>\$0</i> <i>\$0**</i> <i>All costs</i>
SKILLED NURSING FACILITY CARE* <i>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility</i> <i>Within 30 days after leaving the hospital</i> <i>First 20 days</i> <i>21st thru 100th day</i> <i>101st day and after</i>	 <i>All approved amounts</i> <i>All but \$[124] a day</i> <i>\$0</i>	 <i>\$0</i> <i>\$0</i> <i>\$0</i>	 <i>\$0</i> <i>Up to \$[124] a day</i> <i>All costs</i>
BLOOD <i>First 3 pints</i> <i>Additional amounts</i>	<i>\$0</i> <i>100%</i>	<i>3 pints</i> <i>\$0</i>	<i>\$0</i> <i>\$0</i>
HOSPICE CARE <i>You must meet Medicare's requirements, including a doctor's certification of terminal illness.</i>	<i>All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care</i>	<i>Medicare copayment/coinsurance</i>	<i>\$0</i>

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

** Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physi- cian's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, <i>First \$[131] of Medicare Approved Amounts*</i> <i>Remainder of Medicare Approved Amounts</i>	 \$0 <i>Generally 80%</i>	 \$0 <i>Generally 20%</i>	 \$[131] (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD <i>First 3 pints</i> <i>Next \$[131] of Medicare Approved Amounts*</i> <i>Remainder of Medicare Approved Amounts</i>	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$[131] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
<i>—Medically necessary skilled care services and medical supplies</i>	<i>100%</i>	<i>\$0</i>	<i>\$0</i>
<i>—Durable medical equipment First \$[131] of Medicare Approved Amounts*</i>	<i>\$0</i>	<i>\$0</i>	<i>\$[131] (Part B deductible)</i>
<i>Remainder of Medicare Approved Amounts</i>	<i>80%</i>	<i>20%</i>	<i>\$0</i>

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[992]	\$[992](Part A deductible)	\$0
61 st thru 90th day	All but \$[248] a day	\$[248] a day	\$0
91 st day and after:			
—While using 60 lifetime reserve days	All but \$[496] a day	\$[496] a day	\$0
—Once lifetime reserve days are used:			
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101st day and after	All approved amounts All but \$[124] a day \$0	\$0 \$0 \$0	\$0 Up to \$[124] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

** Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, <i>First \$[131] of Medicare Approved Amounts*</i>	\$0	\$0	\$[131] (Part B deductible)
<i>Remainder of Medicare Approved Amounts</i>	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD <i>First 3 pints</i> <i>Next \$[131] of Medicare Approved Amounts*</i>	\$0 \$0	All costs \$0	\$0 \$[131] (Part B deductible)
<i>Remainder of Medicare Approved Amounts</i>	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[131] of Medicare Approved Amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* <i>Semiprivate room and board, general nursing and miscellaneous services and supplies</i> <i>First 60 days</i> <i>61st thru 90th day</i> <i>91st day and after:</i> —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	<i>All but \$[992]</i> <i>All but \$[248] a day</i> <i>All but \$[496] a day</i> <i>\$0</i> <i>\$0</i>	<i>\$[992](Part A deductible)</i> <i>\$[248] a day</i> <i>\$[496] a day</i> <i>100% of Medicare eligible expenses</i> <i>\$0</i>	<i>\$0</i> <i>\$0</i> <i>\$0</i> <i>\$0**</i> <i>All costs</i>
SKILLED NURSING FACILITY CARE* <i>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital</i> <i>First 20 days</i> <i>21st thru 100th day</i> <i>101st day and after</i>	<i>All approved amounts</i> <i>All but \$[124] a day</i> <i>\$0</i>	<i>\$0</i> <i>Up to \$[124] a day</i> <i>\$0</i>	 <i>\$0</i> <i>\$0</i> <i>All costs</i>
BLOOD <i>First 3 pints</i> <i>Additional amounts</i>	<i>\$0</i> <i>100%</i>	<i>3 pints</i> <i>\$0</i>	 <i>\$0</i> <i>\$0</i>
HOSPICE CARE <i>You must meet Medicare's requirements, including a doctor's certification of terminal illness.</i>	<i>All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care</i>	<i>Medicare copayment/coinsurance</i>	<i>\$0</i>

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN C

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

** Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physi- cian's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare Approved Amounts*	\$0 Generally 80%	\$[131] (Part B deductible) Generally 20%	\$0 \$0
Remainder of Medicare Approved Amounts			
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[131] of Medicare Approved Amounts*	\$0	\$[131] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[131] of Medicare Approved Amounts*	\$0	\$[131](Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA	\$0	\$0	\$250
First \$250 each calendar year	\$0	80% to a lifetime maxi- mum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
Remainder of Charges			

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[992] All but \$[248] a day All but \$[496] a day \$0 \$0	\$[992] (Part A deductible) \$[248] a day \$[496] a day \$0 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$[124] a day \$0	\$0 Up to \$[124] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsuranc e for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

** Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physi- cian's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare Approved Amounts*	\$0 Generally 80%	\$0 Generally 20%	\$[131] (Part B deductible) \$0
Remainder of Medicare Approved Amounts			
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[131] of Medicare Approved Amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[131] of Medicare Approved Amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$1860] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1860] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1860] DEDUCTIBLE,* *] YOU PAY
HOSPITALIZATION* <i>Semiprivate room and board, general nursing and miscellaneous services and supplies</i> <i>First 60 days</i> <i>61st thru 90th day</i> <i>91st day and after:</i> <i>While using 60</i> <i>Lifetime reserve days</i> <i>Once lifetime reserve days</i> <i>Are used:</i> <i>Additional 365 days</i> <i>Beyond the additional 365 days</i>	<i>All but \$[992]</i> <i>All but \$[248] a day</i> <i>All but \$[496] a day</i> <i>\$0</i> <i>\$0</i>	<i>\$[992] (Part A deductible)</i> <i>\$[248] a day</i> <i>\$[496] a day</i> <i>100% of Medicare eligible expenses</i> <i>\$0</i>	<i>\$0</i> <i>\$0</i> <i>\$0</i> <i>\$0***</i> <i>All costs</i>
SKILLED NURSING FACILITY CARE* <i>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital</i> <i>First 20 days</i> <i>21st thru 100th day</i> <i>101st day and after</i>	<i>All approved amounts</i> <i>All but \$[124] a day</i> <i>\$0</i>	<i>\$0</i> <i>Up to \$[124] a day</i> <i>\$0</i>	<i>\$0</i> <i>\$0</i> <i>All costs</i>
BLOOD <i>First 3 pints</i> <i>Additional amounts</i>	<i>\$0</i> <i>100%</i>	<i>3 pints</i> <i>\$0</i>	<i>\$0</i> <i>\$0</i>
HOSPICE CARE <i>You must meet Medicare's requirements, including a doctor's certification of terminal illness.</i>	<i>All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care</i>	<i>Medicare copayment/coinsurance</i>	<i>\$0</i>

(continued)

***** NOTICE:** *When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

**Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

*[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[1860] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$[1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]*

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1860] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1860] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as physician's Services, inpatient and Outpatient medical and Surgical services and Supplies, physical and Speech therapy, Diagnostic tests, Durable medical Equipment, First \$[131] of Medicare Approved amounts*	\$0	\$[131] (Part B deductible)	\$0
Remainder of Medicare Approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[131] of Medicare Approved amounts*	\$0	\$[131] (Part B deductible)	\$0
Remainder of Medicare Approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[1860] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[1860] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[131] of Medicare approved Amounts*	\$0	\$[131] (Part B deductible)	\$0
Remainder of Medicare approved Amounts	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[1860] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[1860] DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

**** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.***

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[992]	\$[992] (Part A deductible)	\$0
61st thru 90th day	All but \$[248] a day	\$[248] a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$[496] a day	\$[496] a day	\$0
—Once lifetime reserve days are used: —Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21 st thru 100th day	All but \$[124] a day	Up to \$[124] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for out- patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN G

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

** Once you have been billed \$[124] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physi-cian's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare Approved Amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[131] of Medicare Approved Amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[131] of Medicare Approved Amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA	\$0	\$0	\$250
First \$250 each calendar year	\$0	80% to a lifetime maxi- mum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
Remainder of Charges			

PLAN K

** You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[4140] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.*

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[992]	\$[496]/(50% of Part A deductible)	\$[496]/(50% of Part A deductible)♦
61 st thru 90th day	All but \$[248] a day	\$[248] a day	\$0
91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days	All but \$[496] a day \$0	\$[496] a day 100% of Medicare eligible expenses	\$0 \$0***
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$[124] a day \$0	\$0 Up to \$[62] a day \$0	\$0 Up to \$[62] a day ♦ All costs
BLOOD First 3 pints Additional amounts	\$0 100%	50% \$0	50%♦ \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance♦

(continued)

***** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided

in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

****** Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physi- cian's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare Approved Amounts****	\$0	\$0	\$[131] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$4140])*
BLOOD First 3 pints Next \$[131] of Medicare Approved Amounts****	\$0	50%	50%♦
	\$0	\$0	\$[131] (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

*** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[4140] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN K

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[131] of Medicare Approved Amounts*****	\$0	\$0	\$[131] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	10%	10%♦

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[2070] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[992]	\$[744] (75% of Part A deductible)	\$[248] (25% of Part A deductible)♦
61st thru 90th day	All but \$[248] a day	\$[248] a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$[496] a day	\$[496] a day	\$0
—Once lifetime reserve days are used:			
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100th day	All but \$[124] a day	Up to \$[93] a day	Up to \$[31] a day♦
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	75%	25%♦
Additional amounts	100%	\$0	\$0

HOSPICE CARE <i>You must meet Medicare's requirements, including a doctor's certification of terminal illness.</i>	<i>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</i>	<i>75% of copayment/coinsurance</i>	<i>25% of copayment/coinsurance</i> ♦
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***** NOTICE:** *When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN L

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

****** Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physi- cian's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare Approved Amounts****	\$0	\$0	\$[131] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$2070])*
BLOOD First 3 pints	\$0	75%	25%♦
Next \$[131] of Medicare Approved Amounts****	\$0	\$0	\$[131] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

*** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2070] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN L
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[131] of Medicare Approved Amounts*****	\$0	\$0	\$[131] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	15%	5% ♦

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

PLAN M

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* <i>Semiprivate room and board, general nursing and miscellaneous services and supplies</i> <i>First 60 days</i> <i>61st thru 90th day</i> <i>91st day and after:</i> <i>—While using 60 lifetime reserve days</i> <i>—Once lifetime reserve days are used:</i> <i>—Additional 365 days</i> <i>—Beyond the additional 365 days</i>	<i>All but \$[992]</i> <i>All but \$[248] a day</i> <i>All but \$[496] a day</i> <i>\$0</i> <i>\$0</i>	 <i>\$[496]/(50% of Part A deductible)</i> <i>\$[248] a day</i> <i>\$[496] a day</i> <i>100% of Medicare eligible expenses</i> <i>\$0</i>	 <i>\$[496]/(50% of Part A deductible)</i> <i>\$0</i> <i>\$0</i> <i>\$0**</i> <i>All costs</i>
SKILLED NURSING FACILITY CARE* <i>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</i> <i>First 20 days</i> <i>21st thru 100th day</i> <i>101st day and after</i>	 <i>All approved amounts</i> <i>All but \$[124] a day</i> <i>\$0</i>	 <i>\$0</i> <i>Up to \$[124] a day</i> <i>\$0</i>	 <i>\$0</i> <i>\$0</i> <i>All costs</i>
BLOOD <i>First 3 pints</i> <i>Additional amounts</i>	<i>\$0</i> <i>100%</i>	<i>3 pints</i> <i>\$0</i>	 <i>\$0</i> <i>\$0</i>
HOSPICE CARE <i>You must meet Medicare's requirements, including a doctor's certification of terminal illness</i>	<i>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</i>	<i>Medicare copayment/coinsurance</i>	 <i>\$0</i>

**** NOTICE:** *When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN M

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

** Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physi- cian's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment <i>First \$[131] of Medicare Approved Amounts*</i> <i>Remainder of Medicare Approved Amounts</i>	 \$0 <i>Generally 80%</i>	 \$0 <i>Generally 20%</i>	 \$[131] (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD <i>First 3 pints</i> <i>Next \$[131] of Medicare Approved Amounts*</i> <i>Remainder of Medicare Approved Amounts</i>	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$[131] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[131] of Medicare Approved Amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— NOT COVERED BY MEDICARE <i>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</i> <i>First \$250 each calendar year</i> <i>Remainder of Charges</i>	 <i>\$0</i> <i>\$0</i>	 <i>\$0</i> <i>80% to a lifetime maxi- mum benefit of \$50,000</i>	 <i>\$250</i> <i>20% and amounts over the \$50,000 lifetime maximum</i>
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PLAN N

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

**** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.***

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[992] All but \$[248] a day All but \$[496] a day \$0 \$0	\$[992](Part A deductible) \$[248] a day \$[496] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$[124] a day \$0	\$0 Up to \$[124] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsuranc e for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN N

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

** Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physi- cian's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment <i>First \$[131] of Medicare Approved Amounts*</i> <i>Remainder of Medicare Approved Amounts</i>	\$0 Generally 80%	\$0 <i>Balance, other than up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.</i>	\$[131] (Part B deductible) <i>up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.</i>
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD <i>First 3 pints</i> <i>Next \$[131] of Medicare Approved Amounts*</i> <i>Remainder of Medicare Approved Amounts</i>	\$0 \$0 80%	All costs \$0 20%	\$0 \$[131] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[131] of Medicare Approved Amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— NOT COVERED BY MEDICARE <i>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</i>			
<i>First \$250 each calendar year</i>	<i>\$0</i>	<i>\$0</i>	<i>\$250</i>
<i>Remainder of Charges</i>	<i>\$0</i>	<i>80% to a lifetime maxi- mum benefit of \$50,000</i>	<i>20% and amounts over the \$50,000 lifetime maximum</i>

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* <i>Semiprivate room and board, general nursing and miscellaneous services and supplies</i>			
<i>First 60 days</i>	<i>All but \$[1068]</i>	<i>\$0</i>	<i>\$[1068]/(Part A deductible)</i>
<i>61st thru 90th day</i>	<i>All but \$[267] a day</i>	<i>\$[267] a day</i>	<i>\$0</i>
<i>91st day and after:</i> <i>—While using 60 lifetime reserve days</i>	<i>All but \$[534] a day</i>	<i>\$[534] a day</i>	<i>\$0</i>
<i>—Once lifetime reserve days are used:</i>	<i>\$0</i>	<i>100% of Medicare eligible expenses</i>	<i>\$0**</i>
<i>—Additional 365 days</i>	<i>\$0</i>	<i>\$0</i>	<i>All costs</i>
<i>—Beyond the additional 365 days</i>			

SKILLED NURSING FACILITY CARE* <i>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital</i>			
<i>First 20 days</i>	<i>All approved amounts</i>	<i>\$0</i>	<i>\$0</i>
<i>21st thru 100th day</i>	<i>All but \$[133.50] a day</i>	<i>\$0</i>	<i>Up to \$[133.50] a day</i>
<i>101st day and after</i>	<i>\$0</i>	<i>\$0</i>	<i>All costs</i>

<i>SERVICES</i>	<i>MEDICARE PAYS</i>	<i>PLAN PAYS</i>	<i>YOU PAY</i>
<i>BLOOD</i> <i>First 3 pints</i>	<i>\$0</i>	<i>3 pints</i>	<i>\$0</i>
<i>Additional amounts</i>	<i>100%</i>	<i>\$0</i>	<i>\$0</i>
<i>HOSPICE CARE</i> <i>You must meet Medicare's requirements, including a doctor's certification of terminal illness.</i>	<i>All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care</i>	<i>Medicare co-payment/coinsurance</i>	<i>\$0</i>

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[1068]	\$[1068](Part A deductible)	\$0
61 st thru 90 th day	All but \$[267] a day	\$[267] a day	\$0
91 st day and after: —While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0
—Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0**
—Additional 365 days	\$0	\$0	All costs
—Beyond the additional 365 days			
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[133.50] a day	\$0	Up to \$[133.50] a day
101 st day and after	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, F First \$[135] of Medicare Approved Amounts*	 \$0	 \$0	 \$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[1068]	\$[1068](Part A deductible)	\$0
61 st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91 st day and after: —While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0 \$0**
—Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	All costs
Additional 365 days —Beyond the additional 365 days	\$0	\$0	
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21 st thru 100th day	All but \$[133.50] a day	Up to \$[133.50] a day	\$0
101 st day and after	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135] of Medicare	\$0	\$[135] (Part B deductible)	\$0
Approved Amounts*	Generally 80%	Generally 20%	\$0
Remainder of Medicare Approved Amounts			
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved Amounts*	\$0	\$[135] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[135] of Medicare Approved Amounts*	\$0	\$[135](Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1068]	\$[1068] (Part A deductible)	\$0
61st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day \$0	\$0
—Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0**
Additional 365 days —Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100th day	All but \$[133.50] a day	Up to \$[133.50] a day	\$0
101st day and after	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

- A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2000] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[1068]	\$[1068] (Part A deductible)	\$0
61st thru 90 th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after: —While using 60 Lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0
Once lifetime reserve days are used: —Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
Beyond the additional 365 days	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2000] DEDUCTIBLE,**] YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[133.50] a day	Up to \$[133.50] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out- patient drugs and inpatient respite care	Medicare co- payment/coinsuran ce	\$0

***** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$[2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2000] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as physician's Services, inpatient and Outpatient medical and Surgical services and Supplies, physical and Speech therapy, Diagnostic tests, Durable medical Equipment, First \$[135] of Medicare Approved amounts*	\$0	\$[135] (Part B deductible)	\$0
Remainder of Medicare Approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved amounts*	\$0	\$[135] (Part B deductible)	\$0
Remainder of Medicare Approved amounts	80%	20%	\$0

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2000] DEDUCTIBLE, * *] PLAN PAYS	[IN ADDITION TO \$[2000] DEDUCTIBLE,* *] YOU PAY
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE,* * YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[135] of Medicare Approved Amounts*	\$0	\$[135] (Part B deductible)	\$0
Remainder of Medicare — Approved Amounts	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE,* * YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[1068]	\$[1068] (Part A deductible)	\$0
61st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0
—Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0**
—Additional 365 days	\$0	\$0	All costs
—Beyond the additional 365 days			
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[133.50] a day	Up to \$[133.50] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[133.50] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[4620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare co-payment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[1068]	\$[534](50% of Part A deductible)	\$[534](50% of Part A deductible)♦
61 st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0
—Once lifetime reserve days are used: —Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
—Beyond the additional 365 days	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital First 20 days	All approved amounts.	\$0	\$0
21 st thru 100th day	All but \$[133.50] a day	Up to \$[66.75] a day	Up to \$[66.75] a day ♦
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	50%	50% ♦
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	50% of co-payment/coinsurance	50% of Medicare co-payment/coinsurance ♦

***** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**** Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135] of Medicare Approved Amounts****	\$0	\$0	\$[135] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$4620])*
BLOOD First 3 pints	\$0	50%	50% ♦
Next \$[135] of Medicare Approved Amounts****	\$0	\$0	\$[135] (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[4620] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[135] of Medicare Approved Amounts*****	\$0	\$0	\$[135] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	10%	10% ♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[2310] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[1068]	\$[808.50] (75% of Part A deductible)	\$[267] (25% of Part A deductible)♦
61st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0
—Once lifetime reserve days are used: —Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[133.50] a day	Up to \$[100.13] a day	Up to \$[33.38] a day♦
101st day and after	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
BLOOD First 3 pints	\$0	75%	25% ♦
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	75% of co-payment/coinsurance	25% of co-payment/coinsurance ♦

***** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**** Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135] of Medicare Approved Amounts****	\$0	\$0	\$[135] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$[2310])*
BLOOD First 3 pints	\$0	75%	25%♦
Next \$[135] of Medicare Approved Amounts****	\$0	\$0	\$[135] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2310] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN L
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[135] of Medicare Approved Amounts*****	\$0	\$0	\$[135] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	15%	5% ♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN M

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[1068]	\$[534](50% of Part A deductible)	\$[534](50% of Part A deductible)
61 st thru 90 th day	All but \$[267] a day	\$[267] a day	\$0
91 st day and after: —While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0
—Once lifetime reserve days are used: —Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[133.50] a day	Up to \$[133.50] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[135] of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment —First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment	\$0	\$0	\$(135)(Part B deductible)
First \$(135) of Medicare Approved Amounts*			
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN N

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[1068]	\$[1068](Part A deductible)	\$0
61 st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91 st day and after: —While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0
—Once lifetime reserve days are used: —Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21 st thru 100th day	All but \$[133.50] a day	Up to \$[133.50] a day \$0	\$0 All costs
101 st day and after	\$0		
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to [\$20] per office visit and up to [\$50] per emergency room visit. The co-payment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	up to [\$20] per office visit and up to [\$50] per emergency room visit. The co-payment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	\$0	\$0
First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

[(16)](18) Requirements for Application Forms and Replacement Coverage.

(B) Insurance producers shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

2. List policies sold in the past five (5) years which are no longer in force.

(C) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

(D) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its insurance producer, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of the notice signed by the applicant and the insurance producer, except where the coverage is sold without an insurance producer, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(E) The notice required by subsection (18)(D) above for an issuer shall be provided in substantially the following form in no less than twelve (12)-point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE
[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, INSURANCE PRODUCER [OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason (check one):

☐ Additional benefits.

☐ No change in benefits, but lower premiums.

☐ Fewer benefits and lower premiums.

☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment (optional only for Direct Mailers)

☐ Other. (please specify)

1. NOTE: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

(Signature of Insurance Producer or Other Representative)*

[Typed Name and Address of Issuer, Insurance Producer]

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

[(B) Insurance producers shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

2. List policies sold in the past five (5) years which are no longer in force.

(C) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

(D) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its insurance producer, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of the notice signed by the applicant and the insurance producer, except where the coverage is sold without an insurance producer, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(E) The notice required by subsection (D) above for an issuer shall be provided in substantially the following form in no less than twelve (12)-point type:]

[(17)](19) Filing Requirements for Advertising. An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the director of insurance of this state for review or approval by the director to the extent it may be required under state law.

[(18)](20) Standards for Marketing.

(A) An issuer, directly or through its producers, shall—

1. Establish marketing procedures to assure that any comparison of policies by its insurance producers will be fair and accurate;

2. Establish marketing procedures to assure excessive insurance is not sold or issued;

3. Display prominently by type, stamp or other appropriate means, on the first page of the policy the following: **“Notice to buyer: This policy may not cover all of your medical expenses.”;**

4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance; and

5. Establish auditable procedures for verifying compliance with this subsection (A).

[(19)](21) Appropriateness of Recommended Purchase and Excessive Insurance.

[(20)](22) Reporting of Multiple Policies.

[(21)](23) Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates.

(A) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate *[for similar benefits]* to the extent such time was spent under the original policy.

(B) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods *[for benefits similar to those contained in the original policy or certificate]*.

(24) Prohibition Against Use of Genetic Information and Requests for Genetic Testing. This section applies to all policies with policy years beginning on or after May 21, 2009.

(A) An issuer of a Medicare supplement policy or certificate;

1. Shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual; and
2. Shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

(B) Nothing in subsection (24)(A) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from

1. Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or
2. Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group).

(C) An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

(D) Subsection (24)(C) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with subsection (24)A.

(E) For purposes of carrying out subsection (24)(D), an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

(F) Notwithstanding subsection (24)(C), an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

1. The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.
2. The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that --
 - A. Compliance with the request is voluntary; and
 - B. Non-compliance will have no effect on enrollment status or premium or contribution amounts.
3. No genetic information collected or acquired under this Subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.
4. The issuer notifies the secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted.
5. The issuer complies with such other conditions as the secretary may by regulation require for activities conducted under this subsection.

(G) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

(H) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

(I) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of subsection (24)(H) if such request, requirement, or purchase is not in violation of subsection (24)(G).

(J) For the purposes of this section only:

1. "Issuer of a Medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer.

2. "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

3. "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

4. "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

5. "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

6. "Underwriting purposes" means,

- A. Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;
- B. The computation of premium or contribution amounts under the policy;
- C. The application of any pre-existing condition exclusion under the policy; and
- D. Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

[(22)](25) Separability. If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby.

AUTHORITY: section 374.045, RSMo Supp. 2008. Original rule filed Oct. 15, 1998, effective June 30, 1999. Emergency amendment filed May 16, 2005, effective June 1, 2005, expired Feb. 2, 2006. Amended: Filed May 16, 2005, effective Nov. 30, 2005. *Original authority: 374.045, RSMo 1967, amended 1993, 1995.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than \$500 in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities approximately \$4,300 in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing will be held on this proposed amendment at 10:00 a.m. on October 7, 2009. The public hearing will be held at the Harry S Truman State Office Building, Room 530, 301 West High Street, Jefferson City, Missouri. Opportunities to be heard at the hearing shall be afforded to any interested person. Interested persons, whether or not heard, may submit a written statement in support of or in opposition to the proposed rule, until 5:00 p.m. on October 9, 2009. Written statements shall be sent to Tamara Kopp, Department of Insurance, Financial Institutions and Professional Registration, P.O. Box 690, Jefferson City, Missouri 65102.

SPECIAL NEEDS: If you have any special needs addressed by the Americans With Disabilities Act, please notify us at (573) 751-2619 at least five working days prior to the hearing.

APPENDIX C

DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</p>

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

<p>Before You Buy This Insurance</p>

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact [your state insurance department or state senior insurance counseling program] the Missouri Department of Insurance, Financial Institutions, and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330.

[Original disclosure statement for policies that provide benefits for specified limited services.]

<p style="text-align: center;">IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</p>

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact [*your state insurance department or state senior insurance counseling program*] the Missouri Department of Insurance, Financial Institutions, and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</p>

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

<p>Before You Buy This Insurance</p>

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact [*your state insurance department or state senior insurance counseling program*] the Missouri Department of Insurance, Financial Institutions, and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</p>

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

<p>Before You Buy This Insurance</p>

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact [*your state insurance department or state senior insurance counseling program*] the Missouri Department of Insurance, Financial Institutions, and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</p>

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- hospice
- other approved items and services

<p>Before You Buy This Insurance</p>

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact [*your state insurance department or state senior insurance counseling program*] the Missouri Department of Insurance, Financial Institutions, and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330.

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items & services

Before You Buy This Insurance

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact [your state insurance department or state senior insurance counseling program] the Missouri Department of Insurance, Financial Institutions, and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330.

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</p>

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

<p>Before You Buy This Insurance</p>

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact [your state insurance department or state senior insurance counseling program] the Missouri Department of Insurance, Financial Institutions, and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</p>

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact [your state insurance department or state senior insurance counseling program] the Missouri Department of Insurance, Financial Institutions, and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

<p style="text-align: center;">IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</p>

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact [*your state insurance department or state senior insurance counseling program*] the Missouri Department of Insurance, Financial Institutions, and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330.

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<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</p>

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
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Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

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This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

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- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
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[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

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This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items & services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

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- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact [your state insurance department or state senior insurance counseling program] the Missouri Department of Insurance, Financial Institutions, and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330.

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This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

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- hospitalization
- physician services
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- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

<p>Before You Buy This Insurance</p>

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact [your state insurance department or state senior insurance counseling program] the Missouri Department of Insurance, Financial Institutions, and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330.